Hawaii Employer-Union Health Benefits Trust Fund

REFERENCE GUIDE
(EUTF and HSTA VB)

FOR ACTIVES
Effective January 1, 2012 through June 30, 2013

Disclaimer: This Reference Guide offers general information on your health and other benefit plans. Your health benefits are exclusively governed by Hawaii Statutes and the EUTF Administrative Rules, as they are amended from time to time. Nothing in this Guide is intended to amend, change, or contradict the Hawaii Statutes and the EUTF Administrative Rules. This Guide is not a legal document or contract and the information in the Guide is not intended as legal advice or to create any legal or contractual liabilities.

Welcome to Open Enrollment for EUTF Benefit Plans

The Open Enrollment period for EUTF Health and Life insurance plans will be from October 3 through October 21, 2011.

Why is Open Enrollment special?
Now is the time when you can stop and think about health coverage for yourself and your family and determine which plan offered will best meet your needs. During open enrollment you can:

- Add a plan, change from one plan to another, or drop a plan
- Add a dependent or drop a dependent
- Change coverage tiers such as changing from single to family or family to 2-party
- Now is also a good time to tell us if you've had a change of address

Open enrollment is your only opportunity to make these changes without a qualifying event such as needing to enroll a new dependent due to marriage or a birth. Our next plan period will be 18 months long so there won't be another Open Enrollment until the Spring of 2013. Paperwork must be submitted during the open enrollment period for changes to become effective. So, **now is the time to think about health benefits.**

Here are the important dates:

- **Open Enrollment Election Period: October 3 through October 21, 2011**
- New coverage becomes effective: January 1, 2012
- Rates change effective: January 1, 2012
- Plan Period: January 1, 2012 through June 30, 2013

Here's what you need to do now:

- **Know what you are enrolled in now:** What plans are you enrolled in? Who are the dependents enrolled on your plans?
- **Learn what's being offered:** Read this Reference Guide to learn more about the plans. Attend an Open Enrollment Informational Session to get more details and talk to carrier representatives.
- **Make a decision about which plans best suit your needs.**
- **Fill out the appropriate form:** Please refer to page 3 for complete enrollment instructions.

If you don't want to make any changes, do nothing. If you don't fill out a form, your current plan selections and covered dependents will continue into the new plan year.

SPECIAL NOTE: The HMA 90/10 PPO will be insured with HMSA effective January 1, 2012. The plan (coverage) will remain the same but the administrator is changing from HMA to HMSA. If you are enrolled in the HMA 90/10 plan and want to keep that plan, you do not need to fill out an enrollment form. Your enrollment will be transferred from HMA to HMSA.

This guide can be made available to individuals who have special needs or who need auxiliary aids for effective communication (i.e., large print or audiotape), as required by the Americans with Disabilities Act of 1990.

Please contact the EUTF office at 808-586-7390 or toll-free at 1-800-295-0089 for special needs assistance.

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Administrator/Carrier Changes effective January 1, 2012

EUTF 90/10 PPO Plan
The medical carrier for the 90/10 PPO medical plan option will change. This is the plan which is currently administered by HMA. All of the PPO medical plans will be administered by HMSA (Hawaii Medical Service Association). **Note: "90/10" or "80/20" means the carrier pays most medical expenses at 90% or 80%; see page 18 or Guide to Benefits for details.** ***Note: If you are currently enrolled in the 90/10 plan with HMA, your enrollment will be transferred to HMSA. You do not need to submit Form EC-1 if you want to stay in the EUTF 90/10 PPO.***

Employees enrolled in the EUTF HMSA and HMA plans will receive new ID cards from HMSA.

	What if:	**Then:**
Current Benefit Plan		**Your Plan Effective January 1, 2012**
EUTF 90/10 PPO - HMA	**I do not submit the Form EC-1?**	EUTF 90/10 PPO - HMSA

* HSTA VB refers to plans created for HSTA members who were previously enrolled in the HSTA VEBA plan.

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Life Insurance
The EUTF and HSTA VB life insurance plan will now be insured by Royal State National (RSN). Beneficiary information on file will be transferred to RSN.

The life insurance benefit for active employees will change to $38,361, effective January 1, 2012.

Open Enrollment Instructions

Step 1: Review the choices available to you and decide whether you want to change or keep your plans. If you decide to keep your current benefit plans, you are not required to complete Form EC-1 or EC-1H.

Step 2: Gather Information: If you have questions about your plan choices, please attend an Open Enrollment Informational Session.

During Open Enrollment, all active employees are invited to explore healthcare and insurance options at the informational sessions. See the schedule on page 8. The following insurance carriers and administrator representatives will be on hand to answer your questions about their benefit plans.

Medical plans:	Hawaii Medical Service Association (HMSA) & Kaiser Permanente (Kaiser)

Prescription Drug plan:	HMSA, informedRx, & Kaiser
Supplemental Medical & Drug Plans:	HMSA & Royal State National (RSN)
Dental plan:	Hawaii Dental Service (HDS)
Vision plan:	Vision Service Plan (VSP)
Life insurance:	Royal State National (RSN)
Chiropractic plan:	Royal State National (RSN)

If you are not sure which plan you're enrolled in now, refer to the carrier websites or call the carrier customer service numbers which are on your ID cards. There are also links to carrier websites on the EUTF website, eutf.hawaii.gov.

Step 3: Which Plans do you want to enroll in? Review this Reference Guide and determine which selection of health plans best meets the needs for you and your family. If you want more specific information regarding the different plans, please contact the applicable insurance carrier for your personal copy of their plan details. The EUTF website, eutf.hawaii.gov, also includes links to insurance carriers' web pages along with the latest information regarding the open enrollment.

Step 4: How much will it cost you? Rates/premiums are not available at the time this Guide is being printed. Please check EUTF's websit, eutf.hawaii.gov, for rate information.

Step 5: Who do you need to cover? You can add or drop dependents to your plan, including a spouse or domestic partner (DP) or eligible children. To add a DP, please contact the EUTF to obtain the appropriate forms or go to the EUTF website, eutf.hawaii.gov, to download those forms. Refer to the Employee – Dependent Eligibility section of this Guide for details on who can be enrolled as an eligible dependent.

NOTE: If you are adding a new dependent, you are required to submit your dependent's Social Security number at the initial enrollment (except newborns).
Civil unions will be recognized starting January 1, 2012. EUTF will be sending out additional information regarding covering civil union partners during the latter part of the Fall 2011.

Step 6: Complete the Enrollment Form: **Make your selections on the Form EC-1 for Active Employees, or EC-1H for those eligible for HSTA VB plans. These forms can be downloaded from the EUTF website, eutf.hawaii.gov.**

A: To make changes to your personal information such as your address complete Section 1 on the Form EC-1 or EC-1H.

B: To change your plans or coverage selection, complete Section 3 on the Form EC-1 or EC-1H. Mark all coverage you want – not just changes.

C: To change dependent information, adding or dropping dependents or updating their data, complete Section 4 of the Form EC-1 or EC-1H. Indicate all dependents you are covering.

D. Employees who are enrolled in the HSTA VB plans who change to the EUTF plans may NOT change back to HSTA VB plans in the future. Additionally, employees enrolled in the HSTA VB plans may not enroll in some HSTA VB plans and some EUTF plans – they must be enrolled in all HSTA VB plans or all EUTF plans.

Step 7: **THE MOST IMPORTANT STEP: REVIEW YOUR COMPLETED FORM.** Make sure these are the plans you want and the dependents you want to cover who are eligible to be covered. Sign your form to validate the information. You will not be able to change your selections after Open Enrollment ends, unless you experience a qualifying event.

Last Step: **Submit the completed and signed form to your identified open enrollment designee no later than October 21, 2011.**

The designee may be your office secretary, financial officer, human resources personnel—find out who has been designated by your agency/department. It is very important that you submit your completed form on time.

FORMS SUBMITTED AFTER OCTOBER 21, 2011 WILL BE REJECTED.

The EUTF will send you an enrollment confirmation notice after processing is completed. The confirmation notice allows you to ensure that the changes you submitted were entered correctly. If you note an error, you should notify the EUTF immediately. **However, after October 21, 2011 we can only make changes if there is an error in our processing. We cannot change the selections you made on the original form submitted.**

IMPORTANT: If any of your dependents should be terminated from coverage due to a divorce, or becoming ineligible due to age or loss of student status, do not wait for open enrollment to submit these terminations. You are required to notify the EUTF and make these terminations when these events occur.

A competitive Request for Proposals was issued in the Spring of 2011 for pharmacy benefit management services and a vendor was selected by the EUTF Board of Trustees. However, due to a protest/appeal being filed, the contracts with the current vendors are being temporarily extended. These vendors are informedRx for the EUTF PPO plan and HMSA for the EUTF HMO and HSTA VB plans. Please note that vendors may change in 2012.

Monthly Premiums and Employer / Employee Contributions at 50% - EUTF Plans

Carrier or Administrator	Type of Plan	Coverage	Total Contributions 1/1/2012	Employer Share	Employee Share
HMSA 90/10 PPO RSN Chiropractic	90/10 PPO MEDICAL ONLY and Chiropractic	Self			
		Two Party			
		Family			
HMSA 80/20 PPO RSN Chiropractic	80/20 PPO MEDICAL ONLY and Chiropractic	Self			
		Two-Party			
		Family			
Prescription Drug Only	Prescription Drug Only	Self-only			
		Two-Party			
		Family			
Select either the 90/10 PPO OR the 80/20 PPO AND Prescription Drug for a complete Plan					
HMSA HMO Prescription Drug RSN Chiropractic	HMO Medical, Drug, and Chiropractic	Self			
		Two-Party			
		Family			
Kaiser Comprehensive HMO Kaiser Prescription Drug RSN Chiropractic	HMO Medical, Drug, and Chiropractic	Self			
		Two-Party			
		Family			
Kaiser Basic HMO Kaiser Prescription Drug RSN Chiropractic	HMO Medical, Drug, and Chiropractic	Self			
		Two-Party			
		Family			
HMSA Supplemental HMSA Prescription Drug RSN Chiropractic	Supplemental Medical, Drug, and Chiropractic	Self			
		Two-Party			
		Family			
Royal State Supplemental RSN Prescription Drug RSN Chiropractic	Supplemental Medical, Drug, and Chiropractic	Self			
		Two-Party			
		Family			
HMSA High Deductible Health Plan (HDHP) HMSA Prescription Drug	High Deductible PPO Medical and Drug	Self			
		Two-Party			
		Family			
HDS	Dental	Self			
		Two-Party			
		Family			
VSP	Vision	Self			
		Two-Party			
		Family			
Royal State Life Insurance	Life Insurance	Employee			

Monthly Premiums and Employer / Employee Contributions at 50% - HSTA VB Plans

Carrier or Administrator	Type of Plan	Coverage	Total Contributions 1/1/2012	Employer Share	Employee Share
HMSA HSTA VB 90/10 PPO Prescription Drug VSP Vision, and RSN Chiropractic	90/10 PPO Medical, Drug, Vision, and Chiropractic	Self			
		Two Party			
		Family			
HMSA HSTA VB 80/20 PPO Prescription Drug VSP Vision, and RSN Chiropractic	80/20 PPO Medical, Drug, Vision, and Chiropractic	Self			
		Two-Party			
		Family			
Kaiser Comprehensive HMO Prescription Drug VSP Vision, and RSN Chiropractic	HMO Medical, Drug, Vision, and Chiropractic	Self			
		Two-Party			
		Family			
HMSA HSTA VB Supplemental HMSA Prescription Drug VSP Vision, and RSN Chiropractic	Supplemental Medical, Drug, Vision, and Chiropractic	Self			
		Two-Party			
		Family			
HDS	Dental	Self			
		Two-Party			
		Family			
HDS Supplemental	Supplemental Dental	Self			
		Two-Party			
		Family			
VSP	Vision	Self			
		Two-Party			
		Family			
Royal State Life Insurance	Life Insurance	Employee			

Schedule of Open Enrollment Informational Sessions for Active Employees

Schedule for Actives			
Date	**Location**	**Room**	**Time***
Oct. 3	Hilo	Aunt Sally's Lu'au Hale	1:30pm – 3:00pm, 4:00pm – 5:30pm
Oct. 4	Maui	Kahului Community Center	1:30pm – 3:00pm, 4:00pm – 5:30pm
Oct. 5	Pearl City	Pearl City High School Café	1:30pm – 3:00pm, 4:00pm – 5:30pm
Oct. 6	Kaneohe	Castle High School Café	1:30pm – 3:00pm, 4:00pm – 5:30pm
Oct. 7	Kona	Old Kona Airport	1:30pm – 3:00pm, 4:00pm – 5:30pm
Oct. 10	Lanai	Lanai Community Center	4:00pm – 5:30pm
Oct. 11	Kauai	War Memorial Convention Center	1:30pm – 3:00pm, 4:00pm – 5:30pm
Oct. 12	State Capitol	State Capitol Auditorium	10:30am – 12:00pm, 2:45pm – 4:15pm
Oct. 13	Maui	Kahului Community Center	1:30pm – 3:00pm, 4:00pm – 5:30pm
Oct. 14	University of Hawaii at Manoa	U.H. Kuykendall Auditorium	11:00am – 12:30pm, 2:45pm – 4:15pm
Oct. 17	State Capitol	State Capitol Auditorium	10:30am – 12:00pm, 2:45pm – 4:15pm
Oct. 18	Kapolei	Kapolei Hale Conference Rooms A & B	1:30pm – 3:00pm, 4:00pm – 5:30pm
Oct. 19	Molokai	Mitchell Pauole Community Center	4:00pm – 5:30pm
Oct. 20	Kapolei	Kapolei Hale Conference Rooms A & B	1:30pm – 3:00pm, 4:00pm – 5:30pm
Oct. 21	State Capitol	State Capitol Auditorium	10:00am – 11:30am, 12:30pm – 2:00pm

* Informational Session presentation to start promptly at the designated start time.

Informational Session Locations

MAUI

Kahului Community Center
275 Uhu Street
Kahului, HI 96732

KAUAI

War Memorial Convention Center
4191 Hardy Street
Lihue, HI 96766

LANAI

Lanai Community Center
8th Street
Lanai City, HI 96763

HAWAII - HILO

Aunt Sally's Lu'au Hale
799 Piilani Street
Hilo, HI 96720

HAWAII - KONA

Old Kona Airport
75-5530 Kuakini Highway
Kailua-Kona, HI 96740

MOLOKAI

Mitchell Pauole Community Center
90 Ainoa Street
Kaunakakai, HI 96748

OAHU

Pearl City High School Café
2100 Hookiekie Street
Pearl City, HI 96822

Castle High School Café
45-386 Kaneohe Bay Drive
Kaneohe, HI 96744

State Capitol Auditorium
415 South Beretania Street
Honolulu, HI 96813

U.H. Kuykendall Auditorium
2445 Campus Road
Honolulu, HI 96822

Kapolei Hale Conference Rooms A & B
1000 Uluohia Street
Kapolei, HI 96707

Employee and Dependent Eligibility

Eligibility for coverage is determined by the Administrative Rules adopted by the EUTF Board of Trustees. Enrollments, terminations, and other changes must be submitted to the EUTF through your designated personnel officer. If you have any questions concerning eligibility provisions, you should e-mail EUTF at eutf@hawaii.gov, or call the EUTF Customer Service Call Center at 808-586-7390 or toll free at 1-800-295-0089 or refer to the Administrative Rules posted on the EUTF website, eutf.hawaii.gov.

Health Plans

Employee Eligibility: The following persons shall be eligible to enroll as employee-beneficiaries in the benefit plans offered or sponsored by the EUTF for Active employees:

- An eligible employee, including an elective officer of the State, county or legislature.
- The surviving spouse or domestic partner (DP) of an employee killed in the performance of duty, provided the spouse or DP does not remarry or enter into another domestic partnership.
- The unmarried child of an employee killed in the performance of duty, provided the child is under age 19 and has no surviving parent.

Dependent Eligibility: The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the EUTF for Active employees:

- The Employee's legal spouse or Domestic Partner (DP).
- Your or your spouse's or DP's children under the age of 26 (for medical coverage). This includes children by birth, marriage, or adoption or legal guardianship to age 18. For dental and vision coverage dependent children are covered to age 19, and from age 19 to 24 if they are unmarried and full time students.
- Coverage can be continued for an unmarried child incapable of self-support due to mental/physical incapacity that existed prior to age 19 or 26 if the child was enrolled prior to the limiting age.
- Child covered by terms of a qualified medical child support order (QMCSO).

Group Life Insurance

Employees are eligible for the group life insurance plan offered by the EUTF.

Special Eligibility Requirements

Domestic Partner: Person in a spouse-like relationship with an employee-beneficiary who meets the following requirements:

1. Intend to remain in a domestic partnership with each other indefinitely.
2. Have a common residence and intend to reside together indefinitely.
3. Jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care.
4. Neither are married or a member of another domestic partnership.
5. Not related by blood in a way that would prevent them from being married to each other in the State of Hawaii.
6. Both at least 18 years of age and mentally competent to contract.

7. Consent to the domestic partnership has not been obtained by force, duress or fraud.
8. Both sign and file a declaration of domestic partnership (affidavit) with the EUTF.

If your domestic partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your domestic partner will be deemed taxable income and reported to you on your W-2. Consult your tax advisor to determine your domestic partner's status. If you determine that your domestic partner is a dependent, submit a completed Affidavit of "Dependency" for Tax Purposes (available along with information/instructions on the EUTF website, eutf.hawaii.gov) to the EUTF. Civil unions will be recognized starting January 1, 2012. EUTF will be sending out additional information regarding covering civil union partners during the latter part of the Fall 2011.

Enrollment

To enroll, you must complete Form EC-1 or EC-1H, Enrollment Form for Active Employees. If you do not enroll eligible members of your family within 30 days of when you or they first become eligible, you must wait until the next Open Enrollment period to do so. The regular plan year for active employees begins July 1 and ends June 30 of the following year.

ID Cards

After you enroll for the first time, you will receive identification cards from the plans as follows:

- HMSA and HDS will issue two identical ID cards showing the name of the subscriber.
- Kaiser and informedRx issue an ID card for each enrolled member of a family upon initial enrollment.
- VSP does not issue ID cards.

Dual Family Enrollment (Two EUTF Employees Family Enrollments) Is Not Allowed

If both you and your spouse are employee-beneficiaries, only one of you may enroll in an EUTF Family plan; or if no other dependents are involved, both may enroll in EUTF Self plans. Dual enrollment in EUTF family plans is not allowed under EUTF Administrative Rule 4.03. If your spouse has coverage outside of the EUTF that provides a family coverage through another employer, this rule does not preclude you from also enrolling in a family coverage plan to cover your spouse. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

Medicare Part B Premium Reimbursement

Retirees and their spouses or domestic partners who are enrolled in an EUTF RETIREE medical plan are eligible for Medicare Part B premium reimbursements. If you are enrolled in an EUTF active employee medical plan, you are not eligible for Medicare Part B reimbursement. However, if you are an active employee, enrolled in Medicare Part B and covered by the EUTF retiree medical plan through your spouse/DP, your spouse/DP is entitled to Medicare Part B reimbursement for you.

Change of Coverage – Special Enrollment Period due to Qualifying Event

You are eligible to change coverage outside the Open Enrollment period for the following reasons:

1. You marry and want to enroll your spouse and newly eligible dependent children.
2. You need to enroll a newborn or newly adopted child. In order to add a newly adopted child to your coverage, you must provide appropriate documents verifying the adoption in order to have the application accepted.
3. You have a change in family status involving the loss of eligibility of a family member (e.g., legal separation, divorce, death, child turns age 26).

4. Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage.
5. You move out of your plan's service area.

To change your coverage, you should complete Form EC-1 or EC-1H and submit it through your employer representative within 30 days of the date of the change. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the EUTF. Dependent children are automatically terminated as of the end of the pay period they attain age 26 and do not require the completion of an application to delete coverage.

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates. These events include: Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, New Hire, Newly Eligible, Placement for Adoption, Reinstatement in Employment, and Return from Authorized Leave of Absence (if not currently enrolled).

End of Coverage

Common situations resulting in loss of coverage for you and your dependents are:
1. You voluntarily terminate coverage.
2. You do not make required premium payments (if applicable).
3. You die, subject to exceptions for your surviving spouse or domestic partner and unmarried children under age 19.

Coverage for your dependents will end if:
1. Your dependent is no longer eligible for coverage.
2. Your dependent enters the uniformed services.
3. You fail to comply with the EUTF Administrative Rules.
4. You file fraudulent claims.

Effective Dates of Coverage for New Hires and Newly Eligible

You have a choice of when you would like your coverage to begin. You may choose either your date of hire or the first day of the first pay period from your date of hire or the first day of the second pay period from your date of hire. This rule also applies to some mid- year changes. If you become newly eligible (i.e., part time to full time employee), your effective date of coverage will be the date the change in employment status occurs.

Although your coverage begins on the date you select, if you need to fill a prescription or go to the doctor prior to receiving your ID cards you should email EUTF at eutf@hawaii.gov. In the email subject line type "URGENT – Confirmation of coverage needed". EUTF checks this email daily and will contact the carrier to rush your enrollment after it receives the EC-1 or EC-1H from your employer.

If you were enrolled in the EUTF with your previous public employer and your coverage is still in effect on the day you begin work with your current employer (COBRA coverage excluded), your coverage begins immediately - so you have no break in coverage. (See Transfer of Employment, below.)

Transfer of Employment
If you transfer from one EUTF employer to another, including transfers within State and/or County employment, coverage will be continued provided that you are still covered by the EUTF (COBRA coverage excluded) when you begin in your new position.

Effective Date of Termination
In general, when an event causes your or your dependent's coverage to terminate, such termination will be effective on the first day of the first pay period following the occurrence of the event, e.g., divorce, end of domestic partnership, death, surviving spouse remarries, or child ceases to be eligible for coverage. There may be certain instances in which the effective date of termination is different. You may obtain additional information by referring to the EUTF Administrative Rules that are posted on the EUTF website, eutf.hawaii.gov.

Enrollment in EUTF benefit plans is contingent on meeting all eligibility criteria detailed in the EUTF Administrative Rules. Any enrollment application may be rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.

An enrollment application shall be rejected if:
1. The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
2. The application is not filed within the time limitations prescribed by the rules;
3. The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
4. The employee-beneficiary owes past due contributions or other amounts to the EUTF; or
5. Acceptance of the application would violate applicable federal or state law or any other provision of the rules.

Employee-beneficiaries will be notified by mail of the rejection of any enrollment application.

Premium Conversion Plan - State of Hawaii Employees Only

Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://hawaii.gov/hrd/.

By electing to participate in the Premium Conversion Plan (PCP), please note that:

1. Your authorization will automatically continue year-to-year for the duration of the plan until you change or cancel your participation in the PCP during the Open Enrollment period or as provided under number 2 below.
2. If you have an allowable change in status (marriage, birth or adoption of children, divorce, etc.), you must complete/file all the required PCP forms within 90 days of the event, to change or cancel your reduction in pay (otherwise, changes can be made only during the Open Enrollment period). Please note that you must notify the EUTF within 30 days of the event in order to make the change in coverage.

3. Allowable changes/cancellations will generally take effect the month after you file, so to avoid the risk of losing money, you need to file the forms as soon as possible. Changes in pre-tax payroll deductions are always done after receipt of the PCP-2 form; never retroactively.
4. Your election, in the absence of an allowable change in status, cannot be changed for the current plan year.
5. If you change/cancel your health insurance plan coverage, but your PCP change/cancellation is not allowable, your PCP authorization will still remain in effect through the end of the plan year, and your payments will be forfeited, until PCP change/cancellation forms are filed and approved during the next Open Enrollment period.

Administrative Appeals

Under EUTF Administrative Rule 2.04, a person aggrieved by one of the following decisions by the EUTF may appeal to the EUTF Board of Trustees (Board) for relief from that decision:

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the EUTF;
2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF; or
4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF.

The first step in the appeal process is an appeal to the EUTF administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the EUTF's office within thirty days of the date of the decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the EUTF administrator nor the Board shall be required to hear any appeal that is filed after the thirty-day period has expired. The written appeal need not be in any particular form but should contain the following information:

1. The aggrieved person's name, address, and telephone number;
2. A description of the decision with respect to which relief is requested, including the date of the decision;
3. A statement of the relevant and material facts; and
4. A statement as to why the aggrieved person is appealing the decision, including the reasons that support the aggrieved person's position or contentions.

If the aggrieved person is dissatisfied with the EUTF administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within ninety days of its being filed in the EUTF's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the Board. A written appeal to the Board must be filed in duplicate in the EUTF's office. The written appeal need not be in any particular form but shall contain the following information:

1. The aggrieved person's name, address and telephone number;
2. A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;

3. A description of the decision with respect to which relief is requested, including, the date of the decision;
4. A complete statement of the relevant and material facts;
5. A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
6. A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

Subject to applicable federal and state law, the Board may reject any appeal that does not contain the foregoing information.

The Board at any time may request the aggrieved person or any other party to the proceeding to submit a statement of additional facts or a memorandum, the purpose of which is to clarify the party's position or a specific factual or legal issue.

The Board shall grant or deny the appeal within a reasonable amount of time. The Board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the Board may set such hearing before the Board, a special, or standing committee of the board, a hearings officer, or any other person or entity authorized by the Board to hear the matter in question. Please note that nothing in the EUTF Administrative Rules requires the Board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the EUTF Administrative Rules by submitting such a waiver in writing to the EUTF's office. The Board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

For emergency appeals regarding the EUTF PPO Plan or EUTF Prescription Drug Plan, please refer to the EUTF Administrative Rule 2.05 for information on this appeal process.

Medical Plan Options

Medical coverage is important to everyone. The Plans offered by the EUTF provide preventive care benefits to keep you healthy and many other benefits to help during those times when you are not. The EUTF and HSTA VB plans offer the following Plan options:

- Preferred Provider Organization (PPO) 90/10 Plans
- Preferred Provider Organization (PPO) 80/20 Plans
- Prescription Drug Plan
- Health Maintenance Organization (HMO) Plans
- High Deductible Health Plan (HDHP) (EUTF only)
- Supplemental Medical Plans for those who are covered under another plan, such as a spouse's plan

Understanding the Plan Designs
Preferred Provider Organization Plans (PPO) - EUTF 90/10 or 80/20 or HSTA VB 90/10 or 80/20

A PPO plan is a medical plan that is based on a network of preferred medical providers who have contracts with the carrier. Coverage is also available if you go to a provider who is not in the network A PPO gives you the flexibility to visit the providers you choose – inside or outside of the Plan's network. However, your out of pocket medical costs will be lower if you receive care from an in-network provider or facility. The numbers in the plan titles – 90/10 or 80/20 – refer to the percent of eligible charges that the carrier pays for most services – 90% or 80% - and the amount the employee is responsible for, 10% or 20%. It's important to note that when you participate in a PPO, you are responsible for ensuring that the services and care you receive are covered by your Plan. If you use an out-of-network provider, your out of pocket costs will be higher and you'll often be responsible for submitting your own claims.

Health Maintenance Organization (HMO) - EUTF HMSA or Kaiser Comprehensive or Basic or HSTA VB Kaiser Comprehensive

Under an HMO, you agree to use the health care professionals and facilities associated with that HMO. Except in emergencies, HMO's don't cover the cost of services you receive from doctors or other providers outside of the HMO's network. With an HMO, there are no deductibles or claim forms. After a copayment for each office visit, most medical expenses are covered at 100%. You must select a Primary Care Provider to coordinate your care.

Supplemental Medical Plan (Dual Coverage) - EUTF or HSTA VB Supplemental or Royal State National Supplemental

If you have a medical plan through your non-State/County spouse or another source, you can choose these plans. Expenses that are not covered by the other primary medical plan such as that plan's copays or coinsurance are paid under these plans. Covered expenses include copays for prescription drugs so there is not a separate drug plan offered with the supplemental plans. You can enroll in a supplemental plan **only** if you have another medical plan coverage not provided through the State or counties.

High Deductible Health Plan (HDHP) - HMSA HDHP

An HDHP plan is a PPO plan with a large calendar year deductible. HDHP participants are allowed to open and fund tax advantaged savings vehicles [Health Savings Accounts (HSA)] which can be used to cover medical expenses not paid by the Plan. Contributions to the HSA help you build savings for current and future medical expenses that fall within the deductible of the HDHP.

The EUTF HDHP's calendar year deductible is:

- $1,500 for self enrollment
- $3,000 for family enrollment which applies to all family member claims

Once the self or family deductible has been met, HMSA will pay most covered expenses at 90% if you use a network provider. The deductible, the 10% copayments and the drug copayments that you are responsible for apply to the calendar out of pocket limit:

- $4,000 total out of pocket expense for self enrollment
- $8,000 total out of pocket expense for family enrollment

Once the out of pocket limit is met, all other covered network expenses in the calendar year are paid in full.

Other important features of the plan include:

- Preventive care services are paid in full before the deductible applies
- Prescription drug expenses do apply to the deductible
- For employees with Family enrollment, the full Family deductible must be met before the Plan will pay for any expenses except for those for preventive care services
- The deductible and the out of pocket limit start anew every January 1
- Members are responsible for the payment of all expenses which are applied to the deductible and copayments

For more information on the HDHP and Health Savings Accounts, please refer to the HMSA website www.HMSA.com.

**In general, you will not be eligible for the HDHP/HSA option if you have any other health coverage that would apply to services covered by the HDHP/HSA. For example, if your spouse has other health coverage through his or her employer, your spouse may not be eligible for coverage under the HDHP/HSA option. Also, participation in a flexible spending account (FSA) arrangement may limit your ability to obtain coverage under the HDHP/HSA option.*

Chiropractic Plan Benefits (Royal State National)

Royal State National Insurance Company, Ltd., through ChiroPlan Hawaii, Inc. is the provider of the chiropractic benefits. The chiropractic benefit is packaged with all active medical plans except the EUTF High Deductible Health Plan.

The plan benefits include the initial exam, any necessary x-rays (when taken in a ChiroPlan provider's office), therapeutically necessary chiropractic treatment and therapeutic modalities. For EUTF, the co-payment is $15 per visit up to 20 visits per calendar year. For HSTAVB, the co-payment is $12 per visit up to 20 visits per calendar year. Chiropractic services must be received by a credentialed ChiroPlan Provider. A complete list of ChiroPlan doctors and plan information may be obtained from

the EUTF website, eutf.hawaii.gov. Please refer to the plan certificate for complete information on benefits, limitations and exclusions.

Benefit Plan Summaries

The summary charts on the following pages (pages 18-24) are intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions apply. For complete information on plan benefits, please refer to the HMSA, Kaiser, informedRx or RSN Guide to Benefits, which may be obtained from HMSA, Kaiser, informedRx or RSN directly or from the EUTF website, eutf.hawaii.gov. In the case of a discrepancy between the summary, charts and other information below and the language contained in the Guide to Benefits, the language in the Guide to Benefits will take precedence.

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – EUTF

Plan Design	EUTF 90/10 PPO Plan		EUTF 80/20 PPO Plan	
Carrier	**HMSA**		**HMSA**	
General	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Single/Family	None	$100 per person; $300 per family	None	
Out-of-pocket limit Single/Family	$2,000 / $6,000		$2,500 / $7,500	
Lifetime Benefit Maximum	Unlimited		Unlimited	
Policy Year Benefit Maximum	None		None	
Physician Services	**YOU PAY:**		**YOU PAY:**	
Primary Care Office Visit	10%	30%	$14	$14
Specialist Office Visit	10%	30%	$14	$14
Routine physical exams	No Charge	No Charge	No Charge	No Charge
Screening Mammography	No Charge	30%*	No Charge	No Charge
Immunizations	No Charge	No Charge	No Charge	No Charge
Well Baby Care Visits	No Charge	30%*	No Charge	No Charge
Maternity	Same as any other condition	Same as any other condition	10%	10%
Second opinion – surgery	10%	30%	$14	$14
Emergency Room (ER care)	10%	10%*	$20	$20
Ambulance	10%	30%	20%	20%
Inpatient Hospital Services				
Room & Board	10%	30%	20%	20%
Ancillary Services	10%	30%	20%	20%
Physician services	10%	30%	$20	$20
Surgery	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Outpatient Services				
Chemotherapy/ Radiation Therapy	10%	30%	20%	20%
Surgery	10%	30%	20%	20%
Diagnostic Lab	10%	30%	No Charge	No Charge
Diagnostic X-ray	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Mental Health Services				
Inpatient Care	10%	30%	20%	20%
Outpatient Care	10%	30%	20%	20%
Other Services				
Durable Medical Equipment	10%	30%	20%	20%
Home Health Care	No Charge	30%	20%	20%
Hospice Care	No Charge	Not Covered	No Charge	No Charge
Nursing Facility - Skilled Care	10%, 120 days / CY	30%, 120 days/ CY	20%, 120 days / CY	20%, 120 days / CY
Physical & Occupational Therapy	10%	30%	20%	20%
Notes:	*Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 23.		For prescription drug coverage, refer to the PPO plan on page 23.	

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – EUTF continued

Plan Type Plan Design	Comprehensive	HMO Basic	EUTF
Carrier **General**	**Kaiser***	**Kaiser***	**HMSA**
Deductible Single/Family	None/None	None/None	None/None
Out-of-pocket limit Single/Family	$2,000 / $6,000	$2,000 /$6,000	$1,500 / $4,500
Lifetime Benefit Maximum	None	None	None
Policy Year Benefit Maximum	None	None	None
Physician Services	**YOU PAY:**	**YOU PAY:**	**YOU PAY:**
Primary Care Office Visit	$15	$25	$15
Specialist Office Visit	$15	$25	$15
Routine physical exams	No Charge	No Charge	$15
Screening Mammography	No Charge	No Charge	No Charge
Immunizations	No charge	No charge	No Charge
Well Baby Care Visits	No Charge	No Charge	No Charge
Maternity	Routine OB care: no charge, after confirm of pregnancy	No Charge, after confirmation of pregnancy	No Charge, Routine Pre/Post Natal Care & Delivery
Second opinion – surgery	$15	$25	$15
Emergency Room (ER care)	$50	$75	$25
Ambulance	20%	20%	20%
Inpatient Hospital Services			
Room & Board	No Charge	$100/ day (exc. routine post-partum days)	No Charge
Ancillary Services	No Charge	No Charge	No Charge
Physician services	No Charge	No Charge	No Charge
Surgery	No Charge	No Charge	No Charge
Anesthesia	No Charge	No Charge	No Charge
Outpatient Services			
Chemotherapy/ Radiation Therapy	$15	$25	$15
Surgery	$15	$25	$15
Diagnostic Lab	$15/ department/ day	50%	No Charge
Diagnostic X-ray	$15/ department/ day	50%	$15 per X-ray
Anesthesia	$15	$25	$15
Mental Health Services			
Inpatient Care	No Charge	$100	No Charge
Outpatient Care	$15	$25	No Charge
Other Services			
Durable Medical Equipment	20%	Not Covered	20%
Home Health Care	No Charge	No Charge	No Charge
Hospice Care	No Charge	No Charge	No Charge
Nursing facility - Skilled Care	No Charge, 100 days/ benefit period	No Charge, 60 days/ benefit period	No Charge, 100 days/ CY
Physical & Occupational Therapy	$15	$25	$15 (Outpatient)
Notes:	For prescription drug coverage, refer to the Kaiser HMO plan on page 23.		For prescription drug coverage, refer to the HMO plan on page 23.

*For Kaiser members only:

1. Except for certain situations outlined in your *Group Medical and Hospital Service Agreement*, all claims, disputes, or causes of action arising out of or related to your *Group Medical and Hospital Service Agreement*, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties give up the right to jury or court trial. For a complete description of arbitration information, please see your *Group Medical and Hospital Service Agreement.*
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – EUTF continued

Plan Type	**HDHP**		**Supplemental**	
Carrier	**HMSA**		**Royal State**	**HMSA**
General	In-Network	Out-of-Network		
Annual Deductible Single/Family	$1,500 / $3,000		None/None	None/None
Annual Out-of-pocket limit Single/Family	$4,000 / $8,000		None	$10,000
Lifetime Benefit Maximum	None		None	None
Policy Year Benefit Maximum	None		Medical svcs: $3,100; Rx: $200/$600	None
Physician Services	**YOU PAY:**		**YOU PAY:**	**YOU PAY:**
Primary Care Office Visit	10%*	30%*	Co-pay covered	50%
Specialist Office Visit	10%*	30%*	Co-pay covered	50%
Routine physical exams	No Charge[1]	No Charge[1]	Co-pay covered	No Charge
Screening Mammography	No Charge	30%	Co-pay covered	No Charge (In-network): 50% (Out-of-Network)
Immunizations	No Charge	No Charge	Co-pay covered	50%
Well Baby Care Visits	No Charge	30%	Co-pay covered	No Charge (In-network): 50% (Out-of-Network)
Maternity	Same as any other condition	Same as any other condition	Co-pay covered	Same as any other condition
Second opinion – surgery	10%*	30%*	Co-pay covered	50%
Emergency Room (ER care)	10%*	10%*	Co-pay covered	50%
Ambulance	10%*	30%*	Co-pay covered	50%
Inpatient Hospital Services				
Room & Board	10%*	30%*	Co-pay covered	50%
Ancillary Services	10%*	30%*	Co-pay covered	50%
Physician services	10%*	30%*	Co-pay covered	50%
Surgery	10%*	30%*	Co-pay covered	50%
Anesthesia	10%*	30%*	Co-pay covered	50%
Outpatient Services				
Chemotherapy/ Radiation Therapy	10%*	30%*	Co-pay covered	50%
Surgery	10%*	30%*	Co-pay covered	50%
Diagnostic Lab	10%*	30%*	Co-pay covered	50%
Diagnostic X-ray	10%*	30%*	Co-pay covered	50%
Anesthesia	10%*	30%*	Co-pay covered	50%
Mental Health Services				
Inpatient Care	10%*	30%*	Co-pay covered	50%
Outpatient Care	10%*	30%*	Co-pay covered	50%
Other Services				
Durable Medical Equipment	10%*	30%*	Co-pay covered	50%
Home Health Care	0%*	30%*	Co-pay covered	50%
Hospice Care	0%*	Not Covered	Co-pay covered	No Charge (In-network): Not Covered (Out-of-Network)
Nursing facility - Skilled Care	10%*,120 days/CY	30%*,120 days/CY	Co-pay covered	50%, 120 days / CY
Physical & Occupational Therapy	10%*	30%*	Co-pay covered	50%
Notes:	*Annual Deductibles apply Deductible must be met either single or total family before expenses are paid at 90% Up to $300 in cash incentives through the Rewards Program Optional: Health Savings Account For prescription drug coverage, refer to the PPO plan on page 23.		*Refer to Reimbursement information under Drug Plans on page 23	*Refer to Reimbursement information under Drug Plans on page 23

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – HSTA VB

Plan Design	**HSTA VB 90/10 PPO Plan**		**HSTA VB 80/20 PPO Plan**	
Carrier	**HMSA**		**HMSA**	
General	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Single/Family	None	$100 per person; $300 per family	None	
Out-of-pocket limit Single/Family	$2,000 / $6,000		$2,500 / $7,500	
Lifetime Benefit Maximum	Unlimited		Unlimited	
Policy Year Benefit Maximum	None		None	
Physician Services	**YOU PAY:**		**YOU PAY:**	
Primary Care Office Visit	10%*	30%	20%	20%
Specialist Office Visit	10%*	30%	20%	20%
Routine physical exams	No Charge*	No Charge*	No Charge	No Charge
Screening Mammography	No Charge*	30%*	No Charge	No Charge
Immunizations	No Charge*	30%	20%	20%
Well Baby Care Visits	No Charge*	30%*	No Charge	No Charge
Maternity	Same as any other condition	Same as any other condition	20%	20%
Second opinion – surgery	10%*	30%	20%	20%
Emergency Room (ER care)	10%*	10%*	20%	20%
Ambulance	10%*	30%	20%	20%
Inpatient Hospital Services				
Room & Board	10%*	30%	20%	20%
Ancillary Services	10%*	30%	20%	20%
Physician services	10%*	30%	20%	20%
Surgery	10%*	30%	20%	20%
Anesthesia	10%*	30%	20%	20%
Outpatient Services				
Chemotherapy/ Radiation Therapy	10%*	30%	20%	20%
Surgery	10%*	30%	20%	20%
Diagnostic Lab	10%*	30%	No Charge	No Charge
Diagnostic X-ray	10%*	30%	20%	20%
Anesthesia	10%*	30%	20%	20%
Mental Health Services				
Inpatient Care	10%*	30%	20%	20%
Outpatient Care	10%*	30%	20%	20%
Other Services				
Durable Medical Equipment	10%*	30%	20%	20%
Home Health Care	No Charge*	30%	No Charge	No Charge
Hospice Care	No Charge*	Not Covered	No Charge	No Charge
Nursing Facility - Skilled Care	10%*, 120 days / CY	30%, 120 days / CY	20%, 120 days / CY	20%, 120 days / CY
Physical & Occupational Therapy	10%*	30%	20%	20%
Notes:	*Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 24		For prescription drug coverage, refer to the PPO plan on page 24	

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – HSTA VB continued

Plan Type	HMO Comprehensive	Supplemental
Carrier	**Kaiser***	**HMSA**
General		
Deductible Single/Family	None/None	None/None
Out-of-pocket limit Single/Family	$2,000/ $6,000	None
Annual Benefit Maximum	None	$750,000
Lifetime Benefit Maximum	None	None
Policy Year Benefit Maximum	None	None
Physician Services	**YOU PAY:**	**YOU PAY:**
Primary Care Office Visit	$15	10%
Specialist Office Visit	$15	10%
Routine physical exams	No Charge	No Charge
Screening Mammography	No Charge	No Charge
Immunizations	No Charge	10%
Well Baby Care Visits	No Charge	No Charge
Maternity	Routine OB care: no charge, after confirm of pregnancy	10%; plan limitations apply
Second opinion – surgery	$15	10%
Emergency Room (ER care)	$50	10%
Ambulance	20%	10%
Inpatient Hospital Services		
Room & Board	No Charge	10%; plan limitations apply
Ancillary Services	No Charge	10%
Physician services	No Charge	10%
Surgery	No Charge	10%
Anesthesia	No Charge	10%
Outpatient Services		
Chemotherapy/ Radiation Therapy	$15	10%
Surgery	$15	10%
Diagnostic Lab	$15/ department/ day	10%
Diagnostic X-ray	$15/ department/ day	10%
Anesthesia	$15	10%
Mental Health Services		
Inpatient Care	No Charge	10%
Outpatient Care	$15	10%
Other Services		
Durable Medical Equipment	20%	10%
Home Health Care	No Charge	10%
Hospice Care	No Charge	10%; participating provider only
Nursing facility - Skilled Care	No Charge, 100 days / benefit period	10%, 120 days / CY
Physical & Occupational Therapy	$15	10%
Notes:	For prescription drug coverage, refer to the Kaiser HMO plan on page 24	Refer to Reimbursement information under Drug Plans on page 24

*For Kaiser members only:

1. Except for certain situations outlined in your *Group Medical and Hospital Service Agreement*, all claims, disputes, or causes of action arising out of or related to your *Group Medical and Hospital Service Agreement*, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties give up the right to jury or court trial. For a complete description of arbitration information, please see your *Group Medical and Hospital Service Agreement.*
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

PPO and HMO Prescription Drug Plans – EUTF

COVERAGE	PPO Prescription Drug Plan informedRx [1] [2]		HMO Prescription Drug Plan	
			Kaiser	HMSA[2]
RETAIL PRESCRIPTION PROGRAM (30 day supply)	**Participating Pharmacy**	**Nonparticipating Pharmacy**	**Copayment up to**	**In-Network**
Generic	$5 copayment	$5 + 20% of eligible charges	$15	$5
Preferred Brand Name	$15 copayment	$15 + 20% of eligible charges	$15	$15
Other Brand Name	$30 copayment	$30 + 20% of eligible charges	$15	$30
Injectables and Specialty Drug	20% of eligible charges; Up to $250 maximum; $2,000 out-of-pocket maximum per plan year	Not a benefit	$15	$15
Insulin				
Preferred Insulin	$5 copayment	$5 + 20% of eligible charges	$15	$5
Other Insulin	$15 copayment	$15 + 20% of eligible charges	$15	$15
Diabetic Supplies				
Preferred Diabetic Supplies	No copayment	No copayment	$15	No copayment
Other Diabetic Supplies	$15 copayment	$15	$15	$15
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)			**Kaiser**	
Generic	$10 copayment	Not a benefit	$30	$10
Preferred Brand Name	$35 copayment	Not a benefit	$30	$35
Other Brand Name	$60 copayment	Not a benefit	$30	$60
Insulin				
Preferred Insulin	$10 copayment	Not a benefit	$30	$10
Other Insulin	$35 copayment	Not a benefit	$30	$35
Diabetic Supplies				
Preferred Diabetic Supplies	No copayment	Not a benefit	$30	No copayment
Other Diabetic Supplies	$35 copayment	Not a benefit	$30	$35

For Royal State Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed $10 per prescription drug (RX) up to $100 if enrolled in single coverage or $300 if enrolled in family coverage per policy year. Reimbursement for prescription drugs co-payment count towards the Policy Year Maximum Benefit Payable.

For EUTF Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed $20 per prescription drug (RX) for generic and preferred brand name. For 90-day mail order, reimbursement for prescription drug co-payments charges shall not exceed $35 per prescription drug (RX).

[1] This plan is the prescription drug coverage for the HMSA PPO and HDHP medical options. For the PPO medical plans, the prescription drug coverage is administered by informedRx. For the HDHP medical plan, the prescription drug coverage is administered by HMSA. The plan applies to prescription expenses incurred after the single or family deductible is met.

[2] A competitive Request for Proposals was issued in the Spring of 2011 for pharmacy benefit management services and a vendor was selected by the EUTF Board of Trustees. However, due to a protest/appeal being filed, contracts with the current pharmacy benefit managers (informedRx for the PPO plans and HMSA for the HMSA HMO and HSTA VB plans) are being temporarily extended.

PPO and HMO Prescription Drug Plans – HSTA VB

COVERAGE	PPO Prescription Drug Plan informedRx		HMO Prescription Drug Plan	Supplemental Plan
			Kaiser	HMSA
RETAIL PRESCRIPTION PROGRAM (30 day supply)	**Participating Pharmacy**	**Copayment up to**	**Copayment**	**Plan pays up to**
Generic and Insulin	$5 copayment	$5 + 30% of eligible charges	$10	$10
Brand Name	$15 copayment	$15 + 30% of eligible charges	$10	$25
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	**informedRx**	**Vendor other than informedRx**	**Kaiser**	**HMSA**
Generic and Insulin	$9 copayment	Not a Benefit	$20	$27
Preferred Brand Name	$27 copayment	Not a Benefit	$20	$27

Additional Information for Prescription Drug Plans

The prescription drug plan includes programs that offer a financial incentive for participants to use the generic equivalent or Preferred Brand medication without compromising care as these medications have the same efficacy and are priced lower than Non-Preferred Brand name medications.

Prior Authorizations

The EUTF recognizes that some participants have a clinical need for a Non-Preferred product. In these cases, a prior authorization (PA) process is available for those who require Non-Preferred medications. For the PA process, the prescribing physician must document a clinical failure or drug allergy to the generic or Preferred medication in question.

To avoid paying a higher out-of-pocket co-payment for Non-Preferred medication, participants are encouraged to speak with their physician to determine if a Generic or Preferred medication is appropriate for their treatment. Any change in drug therapy will be on a voluntary basis and should be discussed with a physician.

The following programs apply to the EUTF PPO prescription drug coverage only:

Generic Drug Incentive Program

The Generic Drug Incentive Program requires participants to use a generic equivalent medication, when available, in place of the associated brand name medication. When a generic medication is utilized, the standard generic co-payment will apply. However, if a participant chooses to use a brand medication rather than the generic equivalent, then the co-payment becomes the standard generic co-payment plus the difference in the cost of the generic and brand.

A prior authorization (PA) process is available for those participants who require a Non-Preferred medication.

Utilization Management Guidelines

In an ongoing effort to effectively manage the prescription drug benefit, certain medications are subject to clinical guidelines as part of the prescription benefit plan design. The drug benefit includes the addition of the following three (3) clinical guidelines:

1. ***Quantity Limitations*** – Ensures participants receive the medication in the quantity considered safe by the Food and Drug Administration (FDA), medical studies and input, review, and approval from the informedRx National Pharmacy and Therapeutics (P&T) Committee.
2. ***Step Therapy*** – Requires the use of lower-cost alternatives (First-Line Agents) prior to gaining access to more costly brand name products.
3. ***Contingent Therapy Protocol*** – Means that the medication will be covered when prescribed safely and appropriately, according to FDA approved guidelines and drug coverage protocols. Contingent therapy review often looks for one medication to be tried before another medication will be covered by the plan. This review assures medical necessity, clinical appropriateness, and safety.

Mandatory Mail Order Program for Maintenance Medication

For maintenance medications, the Maintenance Mail Order Program requires participants obtain these medications through a mail service pharmacy after three (3) 30-day fills at a retail pharmacy. Mail order provides a 90-day supply of medication at one low co-payment. As part of the Maintenance Mail Order Program, participants are allowed three (3) 30-day fills at a retail pharmacy in order to determine if a new medication or dosage is right for you. Each new maintenance medication or

change in dosage will allow for the retail fills prior to utilizing mail order. The mail order benefit provides you cost savings through lower co-payments and the convenience of home delivery. Examples of maintenance medications are prescription drugs prescribed for the treatment of ongoing or chronic conditions such as high blood pressure, diabetes, heart disease or thyroid condition.

Non-Specialty medications requiring refrigeration are not subject to the Mandatory Mail Order Program. Participants using insulin or other non-specialty drugs needing refrigeration have the option of obtaining those drugs through a local pharmacy or through this program.

Reference-Based Pricing Program

With this program, the most cost-effective FDA-approved drug will be designated as the Preferred drug within three (3) drug categories or classes.

The Reference-Based Pricing Program applies to the following three drug classes:

1. Cholesterol lowering drugs known as Statins
2. Anti-heartburn/ulcer medications known as Proton Pump Inhibitors or PPIs
3. Allergy medications known as Low or Non-Sedating Antihistamines

For each drug that is included in the Reference-Based Pricing Program, a therapeutic alternative drug exists that is approved by the FDA to treat the same condition. With this program, participants have an opportunity to save a significant amount of money by using the therapeutic alternative drug (also known as the Preferred drug).

Participants prescribed and taking a Preferred drug will pay the generic co-payment for the drug. However, when participants choose to take or continue to take a Non-Preferred drug (the more costly drug) in one of the three drug classes, their co-payment will no longer be a fixed amount, but will vary based on the difference in price of the most cost effective drug (the Preferred drug) and the more costly product (Non-Preferred Drug).

A prior authorization (PA) process is available for those participants who require a Non-Preferred medication.

Specialty Drug Program and Specialty Drug Tier

The EUTF coverage and management of self-administered injectable specialty drugs for the HMSA PPO medical plans is provided by the Specialty Drug Program. The EUTF Specialty Drug Program requires participants obtain specialty medications through the Specialty Rx Program.

The Specialty Rx program uses evidence-based care plans and medication management outreach programs to help participants use these complex medications properly. Medications for the treatment of the following conditions are available through the Specialty Rx Program:

- Arthritic Disorders
- Blood Disorders
- Crohn's Disease
- Cystic Fibrosis
- Fabry Disease
- Gaucher's Disease
- Growth Hormone Deficiency
- Hemophilia
- Hepatitis-C
- HIV/AIDS Wasting
- Infertility
- Immune Deficiency
- Multiple Sclerosis
- Oncology (Cancer)
- Organ Transplant
- Osteoporosis
- Pompe's Disease
- Psoriasis
- Respiratory Syncytial Virus

A fourth tier has been added to the Plan's Formulary to include specialty drugs.

Medications that fall within the Tier 4 (specialty drugs) will be subject to a 20% participant co-insurance. All Tier 4 specialty drugs will have a $250 co-payment maximum per fill and a $2,000 out-of-pocket maximum per plan year.

Exception: Oral oncology medications provided under the Specialty Rx Program will have a Tier 3 copayment instead of Tier 4 copayment.

If you have questions about your prescription drug benefits call informedRx at 1-866-533-6977. Representatives are available 24-hours a day to assist with your questions. You can also visit the informedRx website at www.myinformedrx.com/eutf.asp for additional information on the company.

Dental Plan Benefits [Hawaii Dental Services (HDS)]– EUTF and HSTA VB

Your Plan provides:

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per plan year (July 1 – June 30)	$2,000
DEDUCTIBLE per plan year (July 1 – June 30) (does not apply to benefits covered at 100%)	$50/person
DIAGNOSTIC	
Examinations - twice per calendar year	100%
Bitewing X-rays - twice per calendar year through age 14; once per calendar year thereafter	100%
Other X-rays (full mouth X-rays limited to once every 5 years)	100%
PREVENTIVE	
Cleanings – twice per calendar year • Diabetic Patients – four Cleanings or *Periodontal Maintenance • Expectant Mothers – three Cleanings or *Periodontal Maintenance *Periodontal Maintenance benefit level	100% *80%
Fluoride (once per calendar year through age 19) • Fluoride Varnish – once per calendar year; limited to patients who are at high risk of caries due to root exposure, dry mouth syndrome, history of radiation therapy or other conditions as documented by the dentist.	100%
Space maintainers (through age 17)	100%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molar and bicuspid teeth with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.	100%
RESTORATIVE	
Amalgam (silver-colored) fillings	80%
Composite (white-colored) fillings – limited to the anterior (front) teeth	80%
Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings) Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	60%
ENDODONTICS Pulpal therapy Root canal treatment, retreatment, apexification, apicoectomy	80%
PERIODONTICS Periodontal scaling and root planing – once every two years Gingivectomy, flap curettage and osseous surgery – once every three years Periodontal Maintenance – twice per calendar year after qualifying periodontal treatment	80%
PROSTHODONTICS Fixed bridges (once every 5 years; ages 16 and older) Dentures (complete and partial – once every 5 years; ages 16 and older) Implants (covered as an alternate benefit) when one tooth is missing between two natural teeth	60%
ORAL SURGERY	80%
ADJUNCTIVE GENERAL SERVICES	80%
Palliative treatment (for relief of pain but not to cure)	100%
ORTHODONTICS Maximum amount payable by HDS for an eligible patient shall be $1,000 lifetime per case paid in 8 quarterly payments of $125. Orthodontic services are not covered: *If services were started prior to the date the patient became eligible under this employer's plan. *If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. *If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.	50%

Shaded areas indicate coverage after a Wait Period of 12 months of continuous enrollment in the plan.

Dental Plan Benefits [Hawaii Dental Services (HDS)] – HSTA VB Supplemental Plan

Your Plan provides:

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per plan year (July 1 – June 30)	$750
DIAGNOSTIC	
Examinations - twice per calendar year	50%
Bitewing X-rays - twice per calendar year through age 14; once per calendar year thereafter	50%
Other X-rays (full mouth X-rays limited to once every 5 years)	50%
PREVENTIVE	
Cleanings – twice per calendar year	50%
• Diabetic Patients – four cleanings or *periodontal maintenance	50%
• Expectant Mothers – three cleanings or *periodontal maintenance *Periodontal maintenance benefit level	*45%
Fluoride (once per calendar year through age 19)	50%
• Fluoride Varnish – once per calendar year; limited to patients who are at high risk of caries due to root exposure, dry mouth syndrome, history of radiation therapy or other conditions as documented by the dentist.	
Space maintainers (through age 17)	50%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molar and bicuspid teeth with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.	50%
RESTORATIVE	
Amalgam (silver-colored) fillings	45%
Composite (white-colored) fillings – limited to the anterior (front) teeth	45%
Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	45%
Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	
ENDODONTICS	45%
Pulpal therapy	
Root canal treatment, retreatment, apexification, apicoectomy	
PERIODONTICS	45%
Periodontal scaling and root planing – once every two years	
Gingivectomy, flap curettage and osseous surgery – once every three years	
Periodontal Maintenance – twice per calendar year after qualifying periodontal treatment	
PROSTHODONTICS	
Fixed bridges (once every 5 years; ages 16 and older)	45%
Dentures (complete and partial – once every 5 years; ages 16 and older)	45%
Implants (covered as an alternate benefit) when one tooth is missing between two natural teeth	50%
ORAL SURGERY	50%
ADJUNCTIVE GENERAL SERVICES	45%
Palliative treatment (for relief of pain but not to cure)	50%
ORTHODONTICS Maximum amount payable by HDS for an eligible patient shall be $750 lifetime per case paid in eight quarterly payments of $93.75.)rthodontic services are not covered: *If services were started prior to the date the patient became eligible under this employer's plan. *If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. *If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.	100%

HDS recently updated its public Web site with a fresh, new look that now includes a section exclusively for EUTF members at www.deltadentalhi.org. This section includes a copy of the active dental benefits brochure which includes a summary of the dental benefits. HDS members can also check on their eligibility, view information on past services, find a participating dentist in Hawaii or on the Mainland, print an ID card, and view oral health and wellness information.

Vision Plan Benefits [Vision Service Plan (VSP)] – EUTF and HSTA VB

Your coverage from a VSP Doctor:

Exam covered in full ..... every plan year, after $10 Copay

Prescription Glasses

Lenses covered in full..... every plan year, after $25 Copay

- Single vision, lined bifocal and lined trifocal lenses
- Polycarbonate lenses for dependent children up to age 18

Frame..... every other plan year

- $120 allowance, plus 20% off any out-of-pocket costs

~OR~

Contact Lenses ..... every plan year

- $120 allowance (applies to cost of contacts and fitting & evaluation)

Extra Discounts and Savings

Glasses & Sunglasses

- Average 35-40% savings on all non-covered lens options (such as tints, progressive lenses, anti-scratch coatings, etc.) UV coating is covered at no extra charge.
- 30% off additional glasses & sunglasses, including lens options, from the same VSP doctor on the same day as your Exam. OR get 20% off from any VSP doctor within 12 months of your last Exam.

Contact Lenses

15% off cost of contact lens exam (fitting & evaluation)
VSP has partnered with leading contact lens manufacturers to provide VSP members exclusive offers. Check out www.vsp.com for details.

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

You get the best value from your VSP benefit when you visit a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 6 months to submit a claim to VSP for partial reimbursement, less copays according to the following schedule:

Out-of-Network Reimbursement Amounts

Exam..... Up to $45.00
Single Vision Lenses..... Up to $45.00
Lined Bifocal Lenses..... Up to $65.00
Lined Trifocal Lenses..... Up to $85.00
Frame..... Up to $47.00
Contacts..... Up to $105.00

Before seeing an out-of-network provider, call us at 1-800-877-7195, or go on-line at www.vsp.com to search for a VSP doctor near you!

Life Insurance (Royal State National)

Your life insurance benefit will be $38,361, for active participants.

- Your benefit will reduce once you reach age 65 and continue to reduce as follows:
  - $24,935 for participants age 65 through 69
  - $17,262 for participants age 70 through 74
  - $11,508 for participants age 75 through 79
  - $7,672 for participants age 80 and over

In addition, your life insurance includes the following added benefits:

- Conversion – If your life insurance ceases because of termination of employment or is reduced due to age or retirement, you may convert to an individual whole life insurance policy. You do not need to provide evidence of good health.
- Portability - this provision allows a terminated participant to continue their life insurance at a group discounted rate instead of an individual rate, provided they meet the eligibility requirements.
- Accelerated Benefit – allows you to receive an early payment of a portion of your life insurance if you have a Qualified Medical Condition and meet certain requirements.
- Repatriation of remains benefit – this benefit reimburses an individual who incurs expenses related to transporting your remains back to a mortuary near your primary place of residence if you pass away 200 miles or more away from home.

Existing beneficiary designation information will be provided to Royal State National. Contact Royal State National at (808) 539-1600 or toll free at 1-800-890-9022 if you would like to change your beneficiary. Changes will be effective January 1, 2012. You may download the beneficiary designation form from their website at: www.royalstate.com.

Employee-Beneficiary Responsibilities

Employee-beneficiaries are responsible for:

- Providing current and accurate personal information as prescribed in this booklet;
- Paying the employee's premium contributions in the amount or amounts provided by statute, an applicable bargaining unit agreement, or by the applicable EUTF benefit plan;
- Paying the employee's premium contributions at the times and in the manner designated by the board; and
- Complying with the EUTF's rules.

Any public employer whose current or former employees participate in EUTF benefit plans is responsible for:

- Providing information as requested by the EUTF under section 87A-24(9) of the Hawaii Revised Statutes;
- Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the board;
- Assisting the EUTF in distributing information to and collecting information from the employee-beneficiaries; and
- Complying with the EUTF's rules.

Enforcement Actions of the EUTF

Contribution Shortages

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the EUTF. The notice shall be sent within fifteen days of the date on which the required semi-monthly contribution payment was due. The notice shall require the employee-beneficiary to make full payment of the contribution shortage prior to the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due. Regardless of whether or not the notice of contribution shortage is received by the employee-beneficiary, if the employee-beneficiary fails to make full payment by the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due, the employee-beneficiary's enrollment in the benefit plans offered or sponsored by the EUTF and all coverages for dependent-beneficiaries under such enrollment shall be canceled as set forth in Rule 4.12(c). Cancellation of an employee-beneficiary's coverage pursuant to this rule shall not affect the EUTF's right to collect any and all contribution shortages from the employee-beneficiary.

Other Actions

The EUTF shall have the right and authority to file actions in any court, including but not limited to the courts of the State of Hawaii and the United States of America, to enforce the foregoing obligations and to collect premium contributions. Nothing in this rule is intended to limit or restrict the rights or remedies otherwise available to the EUTF.

Attention: Medicare Eligible Members and/or Dependents Enrolling in EUTF

Attention: Medicare Eligible Members
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you additional choices for prescription drug coverage through Medicare Part D. The EUTF sponsored prescription drug plan, except for the supplemental plans, offers benefits that are as good, or better, than the standard Medicare Part D plan coverage. A summary of your Notice of Creditable Coverage appears below.

If you are enrolled in the supplemental medical plan, your prescription drug coverage is considered to be non-creditable when compared to the standard Medicare Part D plan. A summary of your Notice of Non-Creditable Coverage appears below.

Prescription Drug Benefits

The **Medicare Prescription Drug Program** (Medicare Part D) was established to provide prescription drug coverage for eligible Medicare individuals. Your employer is required to inform you whether or not your prescription drug plan is creditable or non-creditable.

Notice of Creditable Coverage (available at EUTF website at eutf.hawaii.gov)

Since you are or may become eligible for Medicare during the next year, the EUTF is required by law to notify you regarding your rights to the Medicare Part D prescription drug coverage. If you are enrolled in an EUTF plan other than a supplemental plan, your prescription drug benefits are as good as or better than the standard Medicare Part D drug benefits. Although you have the right to join a Medicare Part D prescription drug plan, doing so may disrupt your regular medical coverage, and you do not have to do so at this time. Medicare will not penalize you if you decide to enroll in a Medicare Part D plan in the future, because the prescription drug coverage you now have through the EUTF is creditable coverage.

If you decide to join a Medicare Part D plan, you should compare the different drugs that are available under your current plan with EUTF and the alternative plans. Not all Medicare Part D plans cover the same drugs, nor provide the coverage at the same cost.

Notice of Non-Creditable Coverage (available at EUTF website at eutf.hawaii.gov)

If you are enrolled in a supplemental medical plan, the EUTF has determined that your prescription drug benefits are not as good as or better than the standard Medicare Part D drug benefits. As a rule, you are enrolled in the supplemental medical plan because you are also enrolled in another prescription drug plan and you should have received a Notice of Creditable Coverage from that other plan. If your other plan's prescription drug benefits are also non-creditable coverage, you should consider enrolling in Medicare Part D when you first become eligible to do so. If you don't enroll in Part D when you are first eligible to do so, you may have to pay a penalty (a higher premium) for your Part D coverage when you later do enroll, and you may have to pay that penalty for as long as you are covered under Part D.

It is important to note that if you enroll in a Medicare Part D plan, the EUTF will not reimburse you for the premiums.

Required Notices

The following required notices are available for viewing at EUTF's website at eutf.hawaii.gov:

- **Notice of Creditable and Non-Creditable Coverage** – Refer to page 33 for a description.
- **Women's Health & Cancer Rights Act** – This notice includes information regarding benefits that your health insurance plan is required to provide by the Women's Health and Cancer Rights Act of 1998 for mastectomy-related services.
- **Newborns' & Mothers' Health Protection Act** – This is to notify participants that group health plans and health insurance issuers who offer group insurance coverage may not (under federal law) restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section.
- **Qualified Medical Child Support Order** – This is to notify participants that your health insurance plan honors qualified medical child support orders (QMCSOs), which means that if a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so under the Plan.
- **National Medical Support Notices** – The EUTF (your health benefits plan administrator) also honors qualified National Medical Support Notices (NMSNs), which are similar to a QMCSO, but are issued by a state agency pursuant to a medical child support order.
- **Early Retiree Reinsurance Program Notice** – This is to notify you that you are a plan participant in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. Under this program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs.
- **Continuation of Group Health Coverage Under COBRA: Initial Notice** – This notice includes information on the federal law, commonly known as "COBRA," that requires most employers to offer employees and their covered dependents the opportunity to elect a temporary continuation of health coverage, at group rates, when coverage would otherwise be terminated, because of a "qualifying event".
- **HIPAA Initial Notice: Notice of Privacy Rights** – This notice describes how your medical information may be used and disclosed and how you can get access to this information.
- **Certificate of Creditable Coverage and Preexisting Conditions** – A certificate of creditable coverage shall be provided when your coverage under the Employee Modified Medical Program or the Employee Medical Program ends. This notice also includes information regarding regulations on preexisting conditions.
- **Patient Protection Disclosure** – This notice provides individuals with information regarding their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization.

If you wish to have hard copies of any of these notices, send EUTF an email at eutf@hawaii.gov. In the email indicate the notice(s) you request and your name and mailing address. Or, you may call our Customer Service Call Center at 808-586-7390 or Toll Free at 1-800-295-0089. All requested notices will be mailed to you free of charge.

For More Information

For Questions about…	Please Contact…
Eligibility	**eutf@hawaii.gov** EUTF Customer Service 808-586-7390 or Toll Free: 1-800-295-0089 (Monday through Friday, 7:45 a.m. – 4:30 p.m. HST)
Hawaii Medical Service Association (HMSA)	**www.hmsa.com** 808-948-6499 or Toll Free: 1-800-776-4672 Hilo: 808-935-5441, Kailua-Kona: 808-329-5291 Kahului: 808-871-6295, Lihue: 808-245-3393 (Monday through Friday, 8:00 a.m. – 4:00 p.m. HST)
Kaiser Permanente (Kaiser)	**www.kp.org/hi/EUTF's** 808-432-5955 (Oahu) or Toll Free: 1-800-966-5955 (Neighbor Islands) (Monday through Friday, 8:00 a.m. – 5:00 p.m. HST Saturdays 8:00 a.m. – 12:00 p.m. HST)
informedRx	**www.myinformedrx.com/eutf.asp** 1-866-533-6977 (24/7) **informedMail** 1-866-533-6077 (24/7) **Ascend SpecialtyRx** 1-800-850-9122
Vision Service Plan (VSP)	**www.vsp.com** 808-532-1600 or Toll Free: 1-800-522-5162 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST) Toll Free for Mainland: 1-800-877-7195 (Monday through Friday, 5:00 a.m. – 7:00 p.m. PST Saturdays 6:00 a.m. – 2:30 p.m. PST)
Hawaii Dental Service (HDS)	**www.deltadentalhi.org** 808-529-9310 or Toll Free: 1-866-702-3883 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST)
Royal State National (RSN)	**Chiropractic Benefit** **www.chiroplanhawaii.com** 808-621-4774 or Toll Free: 1-800-414-8845 **Supplemental Medical Plan** **www.rsninc.com** 808-539-1621 or Toll Free: 1-888-942-2447 (Monday through Friday, 8:00 a.m. – 4:30 p.m. HST) **Life Insurance** **www.royalstate.com** 808-539-1621 or Toll Free: 888-942-2447

Plan information can also be found online via the "Links to Carrier Web Sites" located on the EUTF website at eutf.hawaii.gov.